

it meets the other qualifications of a disproportionate share hospital. A high disproportionate share hospital must be licensed by the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification as either a General Medical/Surgical hospital, a Limited Services (as limited by the hospital licensing agency) hospital, a Psychiatric and/or Chemical Dependency hospital or a Medical Specialty (Rehabilitation or other medical specialty) hospital. In addition, the hospital must be licensed as having public ownership and may not be licensed with ownership as follows: proprietary (for profit - single entrepreneur, partnership or corporation), not-for-profit corporation or association, church affiliation, industrial, or public ownership (state or local government - leased to another entity for operation of the hospital).

- (b) Disproportionate share payment adjustments to hospitals that qualify as high disproportionate share hospitals may not exceed one hundred percent (100%) of the costs of furnishing hospital services by the hospital to individuals who either are eligible for medical assistance under this State Plan or have no health insurance (or other source of third party coverage) for services provided during the year less any payments made by Medicaid, other than for disproportionate share payments, and less any payments made by uninsured patients. For purposes of this section, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

- (c) Disproportionate share payments to High Disproportionate Share Hospitals will be made, based on the availability of funds, as follows:

The amount of funds shall be distributed to hospitals on a periodic basis to be determined

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by the Division of Medicaid, based upon the ratio of Mississippi Medicaid patient days for each hospital to the sum of the Mississippi Medicaid patient days of all High Disproportionate Share Hospitals located in Mississippi. However, a hospital may not exceed the limitations for payments described elsewhere in this plan.

For example, the total Title XIX days for Mississippi Medicaid eligible patients for the High Disproportionate Share Hospitals was 225,000; XYZ Hospital had 28,125 of those days; and the total funds to be distributed amounted to \$14,000,000. XYZ Hospital would receive a disproportionate share payment of \$1,750,000 $((28,125 / 225,000) \times \$14,000,000)$.

(2) Low Disproportionate Share Hospitals

(a) A hospital is determined to be a low disproportionate share hospital if it meets the qualifications of a disproportionate share hospital but does not qualify as a High Disproportionate Share Hospital.

(b) Low Disproportionate Share Hospitals shall receive an adjustment to the operating component of their Medicaid prospective rate. The operating component of the Medicaid prospective rate will be increased for Low Disproportionate Share Hospitals by six percent (6%).

(3) Any hospital which is deemed eligible for a disproportionate share payment adjustment and is adversely affected by serving infants who have not attained the age of one (1) year and children who have not attained the age of six (6) years, may within sixty (60) days of the rate letter, request an outlier payment adjustment to the established rate for those individuals. Adversely affected is defined as exceeding the operating cap of the class of the facility. The outlier adjustment is only for claims filed for Medicaid recipients under six (6) years of age and is the difference between the rate subject to the operating cap and the calculation of the rate without applying the operating cap.

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- C. Amended cost reports must be received by the Division of Medicaid on or before the thirtieth (30th) day following the due date of the initially filed cost report in order for that cost report to be used to determine a hospital's eligibility for disproportionate share status for the state fiscal year.
- D. The determination of a hospital disproportionate share status is made annually and is for the period of the federal fiscal year (October 1 - September 30). Once the list of disproportionate share hospitals is determined for a state fiscal year, no additional hospitals will receive disproportionate share status. A hospital will be deleted from disproportionate share status if the hospital fails to continue providing nonemergency obstetric services, if the hospital is required to provide such services.
- L. Legal costs and fees resulting from suits against federal and state agencies administering the Medicaid program are not allowable costs.
- M. Notwithstanding any other subparagraph, depreciation and interest expense shall not exceed the limitations set forth in Appendix F.
- N. Inpatient hospital services provided under the Early Periodic Screening-Diagnostic and Testing (EPSDT) program will be reimbursed at the hospital's Medicaid prospective rate, as set forth in Appendix A.
- O. Out-of-State Hospitals
 Out-of-State hospitals in contiguous states are reimbursed at the lower of (1) the average rate paid a like sized hospital in Mississippi or (2) the inpatient rate established by the Medicaid agency or the domicile state.
- Out-of-state hospitals in states other than contiguous states are reimbursed at the average rate paid a like sized hospital in Mississippi.
- The fiscal agent is responsible for verifying the rate with the Medicaid agency in the domicile state. Verification should be made each six months.
- P. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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Miss State Plan 4.19-A, page 7e
10/11/95

Print ink correction changing
"Q" to "P" Requested by the State.
Via 7/10/95 letter submitting
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Attachment 4.19-A
Page 7e



P 4) Durational Limit Prohibition

In compliance with section 6404 of the Omnibus Budget Reconciliation Act of 1990, no durational limit will be imposed for medically necessary inpatient services 1) provided in disproportionate share hospitals to children under the age of 19 years, or 2) provided in any hospital to an individual under the age of 1 year.

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IV. Appeals

Inpatient hospital providers who disagree with an adjustment to their allowable cost or a calculation in the rate setting information may file an appeal to the Division of Medicaid. The following reasons would be grounds to file an appeal with the Division of Medicaid:

- A. The addition of new and necessary services not requiring CON approval. Notification must be made in writing to the Division of Medicaid within thirty (30) days of implementing the services. The submitted cost figures must be allocated between capital costs, education costs, and operating costs.
- B. The cost of capital improvements receiving CON approval after payment rates were set if those costs were not considered in the calculation. Notification must be made in writing to the Division of Medicaid within thirty (30) days of implementing the services. The submitted cost figures must be allocated between capital costs, education costs, and operating costs.
- C. Costs of improvements incurred because of certification or licensing requirements established after payment rates were set if those costs were not considered in the rate calculation. The appeal must be submitted within thirty (30) days of the change in certification or licensing and must be sent to the Division of Medicaid in writing.
- D. Incorrect data were used or an error was made in the rate calculation.

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- E. Extraordinary circumstances which may include but are not limited to riot, strike, civil insurrection, earthquakes or flood.

The appeal must be in writing, must include the reason for the appeal, and must be made within thirty (30) calendar days after the Division of Medicaid notified the provider of the adjustment. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the appeal. The request for an appeal adjustment must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The burden of proof shall be on the hospital to demonstrate that costs for which the additional reimbursement is being requested are necessary, proper and consistent with efficient and economical delivery of covered patient services.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, or (b) if by hand delivery, on the date delivered.

The hospital will be notified of Medicaid's decision in writing within thirty (30) days of receipt of the hospital's written request, or within thirty (30) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the thirty (30) day period shall be grounds for denial of the request.

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V. MethodA. Prospective Rate

Medicaid will utilize a prospective rate of reimbursement and will not make retroactive adjustments except as specified in this plan. The prospective rates will be determined from cost reports and will be set on a yearly (October 1 - September 30) basis from date established and will be applicable to all facilities with a valid provider agreement.

B. Cost Containment

1. Medicaid, prior to setting the prospective rate for each year, will make appropriate adjustments to account for increased cost as outlined in the Plan and will designate the maximum percentile at the 80th percentile of the operating component cost for each class of facility as outline in Section V, D of this Plan. The percentile is based on the determination of a reimbursement percentile which will enable an efficiently and economically operated hospital to care for Medicaid recipients.
2. The Medicaid Prospective Capital Cost Component will be determined at the hospital's actual occupancy rate.
3. Out-of-State hospital providers with a participation agreement shall be excluded from the determination of the 80th percentile limit on the operation cost component.

C. Class of Facilities

The following statewide classes of facilities shall be used

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for determining the maximum prospective operating cost component. The designated maximum percentile (80th percentile) by class of facility will be utilized to limit payment to high cost providers. General hospitals will be classified based on the number of beds available per the cost report. Free-standing psychiatric hospitals are a separate class of hospitals for rate setting with all bed sizes combined. General hospitals which have a psychiatric unit are reimbursed the same per diem for the psychiatric inpatient days as they are for general medical/surgical inpatient days.

CLASS OF FACILITIES

1. General Hospitals with 0 - 50 Beds
2. General Hospitals with 51 - 100 Beds
3. General Hospitals with 101 - 150 Beds
4. General Hospitals with 151 - 200 Beds
5. General Hospitals with 201 or more Beds
6. Free-Standing Psychiatric Hospitals

D. Setting of Class Ceilings

1. The latest cost report available to Medicaid in each calendar year for each hospital will be reviewed and adjusted:
 - a. to reflect the results of desk review and/or field audits
 - b. to adjust for excessive costs
 - c. to determine if the hospitals general routine operating costs are in excess of the limitations established by 42 CFR 413.30.

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For hospitals having excessive general routine operating costs, appropriate adjustment shall be made.

2. Total cost allocated to the Medicaid Program on the appropriate cost reporting forms shall be classified as a.) capital costs, b.) educational costs, and c.) operating costs. Capital costs are defined by this plan to include those costs reported for Medicare reimbursement purposes such as depreciation, non-employee related insurance, interest, rent, and property taxes (real and personal). Educational costs are defined as those costs normally recorded in the Intern and Resident and Nursing School accounts for Medicare reimbursement purposes. Capital costs and educational costs are to be allocated to the Medicaid Program based upon the number of inpatient Medicaid days to total inpatient days. Operating costs are defined as total Medicaid costs less capital costs and educational costs apportioned to the Medicaid Program.

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3. Medicaid Prospective Capital Cost Component
 - a. Total capital costs apportioned to the Medicaid Program will be divided by actual Medicaid inpatient days.
 - b. In accordance with Section III.K., an amount will be added or deducted for the capital cost applicable to the Medicaid Program for new or deleted services or equipment which requires Certificate of Need approval.
 - c. The addition of 3a. and 3b. shall be called the Medicaid Prospective Capital Cost Component.
4. Medicaid Prospective Educational Cost Component
 - a. Total educational costs apportioned to the Medicaid Program will be adjusted for the number of months between the mid-point of the hospital's reporting year and the mid-point of the calendar year most recently ended by the payroll expense and employee benefits portion of the latest rate of

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